STATE OF UTAH
DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

APPLICATION FOR MEDICATION AIDE CERTIFIED PILOT FACILITY

IMPORTANT INFORMATION:

1. **Laws and Rules:** You are required to understand all Utah laws and rules pertaining to the practice of a Medication Aide Certified. The following applicable laws and rules are available on the Internet at www.dopl.utah.gov:

   - Division of Occupational & Professional Licensing Act
   - General Rules of the Division of Occupational & Professional Licensing
   - Nurse Practice Act
   - Nurse Practice Act Rules

2. **Facility Requirements for Participation:**
   - At least fourteen (14) licensed facilities throughout the state are eligible to participate with no more than a total of twenty (20) sites:
     - Type I and II Assisted Living (4)
     - Hospital Swing Beds – rural area (2)
     - Skilled Nursing facility – both rural and urban (6)
     - ICFMR (2)
   - Residents must be stable and receiving routine medications.
   - Facility must have delegation and supervision protocols in place.
   - Nursing personnel reductions may occur only with Board / Division approval.
   - Facility must utilize a unit-dose pharmacy prepared medication system.
   - Facility must not have any federal or state surveys reveal failure to comply with federal regulations or state rules regarding CNAs, MACs, or patient care.
   - Facility's medication administration error rate must be less than 5% in the past two years.
   - Facility may not have received any survey deficiencies in staffing patterns for the past 2 years.
   - Facility must commit to pay the costs of the course, testing fees, and application fees.
   - If MACs administer medications 24/7, then an RN/LPN must be available to supervise 24/7; the supervision must be on-site for hospital swing beds and skilled nursing facilities; and the supervision may be general (immediately available) for Type I and II Assisted Living facilities and ICFMR facilities.

3. **Training:**
   - Forty hours of classroom instruction shall be offered by an educational institution that currently offers an approved nursing education program.
   - The classroom instructor shall be an approved nursing education program faculty member, RN or APRN who is licensed in good standing and has at least two years of clinical experience and at least 1 year of long-term care nursing experience in the past five years.
   - The curriculum and training program must be approved by the Board / Division prior to implementation.
   - The on-site clinical supervisor for the required twenty hours of clinical experience must be available at all times during the clinical training experience and meet as a minimum:
     - If the supervisor is an employee of the Long-term Care Facility then he/she must be licensed as a RN or APRN in good standing with 1 year experience in long-term care nursing, at least 3 months experience in the specific training facility, and have completed the Department of Health's "Train the Trainer" program.
     - If the supervisor is a faculty member of an approved nursing education program then he/she must be licensed as a RN or APRN in good standing with 1 year experience in long-term care nursing.
     - A MAC supervisor may not delegate his/her responsibilities; when providing clinical instruction/observation of a MAC completing the 20 hours of clinical practice, the supervisor may not perform any other duties but observing and assisting the MAC in training.
   - The faculty to student ratio is 1:1 in the clinical setting.
   - An individual must test within 6 months of taking the medication administration training, and can only have 2 attempts to pass the certification examination within six months of completion, or must complete a new training program.

4. **Mail Complete Application to:**

By U.S. Mail
Division of Occupational & Professional Licensing
P.O. Box 146741
Salt Lake City, Utah 84114-6741

By Delivery or Express Mail
Division of Occupational & Professional Licensing
160 East 300 South, 1st Floor Lobby
Salt Lake City, Utah 84111

3. **Telephone Numbers:** (801) 530-6628
(866) 275-3675 – Toll-free in Utah

4. **Fax Number:** (801) 530-6511

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GENERAL INFORMATION

Applying for: **MEDICATION AIDE CERTIFIED – PILOT FACILITY**

Name of Long-Term Care Facility: _____

Type of Facility: _____

Name of Contact Person: _____ Title: _____

MAILING ADDRESS

Street: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

PERSON COMPLETING THIS APPLICATION

Name: _____ Title / Position: _____

Telephone: _____ Email: _____

Signature: _____ Date: _____

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

Date Approved: _____

Date Denied: _____

Reason for Denial/Other Comments: _____

SUPPORTING INFORMATION

Date of Last Department of Health Regular Survey: _____

Results / Deficiencies: _____

Medication Error Rates (past 2 years):

Date: _____ Rate: _____

Date: _____ Rate: _____

Resident Beds / Estimated Usual Census:

Total Facility Beds: _____

Usual Census: _____

Nursing Personnel Employed/Vacancies:

Employed: _____ RN _____ LPN _____CNA

Vacancies: _____ RN _____ LPN _____CNA

Units including number of residents where MACs will be utilized:

Name of Unit: _____ No. of Residents: _____

Name of Unit: _____ No. of Residents: _____

Name of Unit: _____ No. of Residents: _____

Name of Unit: _____ No. of Residents: _____

CNAs Identified to become Medication Aide Certified: (Use additional copies if needed.)

Name: _____

CNA Certification Number: _____ Length of Employment (months): _____

Name: _____

CNA Certification Number: _____ Length of Employment (months): _____

Name: _____

CNA Certification Number: _____ Length of Employment (months): _____

Name: _____

CNA Certification Number: _____ Length of Employment (months): _____

Name: _____

CNA Certification Number: _____ Length of Employment (months): _____

Name: _____

CNA Certification Number: _____ Length of Employment (months): _____

AFFIDAVIT and RELEASE AUTHORIZATION

To the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, misrepresentation, or omission of material fact.

To the best of my knowledge, the information contained in the application and its supporting document(s) is truthful, correct, and complete; and, discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Division of Occupational and Professional Licensing in conjunction with this application or its supporting documents meet the same standard as set forth above.

Signature of Applicant's Representative: _____

Date of Signature: _____

Printed Name of Applicant's Representative: _____